COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

CHART Phase 2:

Implementation Plan

Beth Israel Deaconess Hospital - Plymouth

HPC approval date: September 21, 2015

Last modified: December 30, 2016

Version: 4

Introduction

This Implementation Plan details the scope and budget for Beth Israel Deaconess Hospital – Plymouth's ("Contractor") Award in Phase 2 of the Health Policy Commission's (HPC) Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program. The Implementation Plan is incorporated by reference into and is subject to the requirements of the Phase 2 Award Contract, including the Phase 2 Terms & Conditions.

Many capitalized terms appearing in the Implementation Plan are defined in the Phase 2 Terms & Conditions or the Phase 2 Request for Proposals (RFP). In addition to capitalized terms, the Implementation Plan may include other acronyms and/or abbreviations whose meaning is understood by Contractor and the HPC in the context of the Implementation Plan. If there is disagreement concerning the meaning of a term, acronym, or abbreviation, the HPC's interpretation shall govern.

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Key personnel

Name	Title	CHART Phase 2 Role
Kevin Coughlin	Interim President and Chief Executive Officer	Operational Investment Director
Peter Smulowitz, MD, MPH	Associate Chief, Department of Emergency Medicine	Clinical Investment Director
Alejandro Mendoza, MD	Chief of Psychiatry	Clinical Investment Director
Melissa Lauffer	Project Manager	Project Manager
Bob Ness	Senior Director, Financial Planning	Financial Designee

Target population

Definition

- All dual eligible patients, and/or
- All emergency department patients with a behavioral health primary diagnosis*,**

Quantification

Dual Eligible***

- 849 discharges per year (inpatient & observation); 566 unique patients
- 2,481 ED visits per year; 1,279 unique patients
  - Combined – 1,561 unique patients

Behavioral Health

- 1,322 discharges per year (inpatient & observation); 1,164 unique patients
- 2,963 ED visits per year; 2,166 unique patients

*ICD-9 Code 293 (delirium) is excluded from the list of inclusion diagnoses

**Target population definition includes all payers and aged 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab

*** Aged and disabled; Medicare primary, MassHealth secondary insurance

Aim Statement

Primary Aim Statements

- Reduce returns by 10% for dual eligible patients by the end of the 24 month Measurement Period
- Reduce ED revisits by 20% for patients with primary BH diagnosis by the end of the 24 month Measurement Period

Secondary Aim Statement*

- Reduce ED LOS for by 10% ED patients with primary BH diagnoses by the end of the 24 month Measurement Period

*Your secondary aim statement is a performance measure only and is not tied to Achievement Payment.

Baseline performance – Returns reduction

		Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Avg.	Total
Hospital-Wide	Returns	116	86	110	120	112	111	111	135	129	141	91	118	115	1380
	Discharges	887	768	872	878	886	898	948	974	967	1028	884	899	907	10889
	Rate (%)	13%	11%	13%	14%	13%	12%	12%	14%	13%	14%	10%	13%	13%	13%
Target Pop: Duals	Returns	7	6	15	11	12	10	13	8	13	15	11	10	11	131
	Discharges	60	58	67	64	61	73	76	77	77	91	73	72	71	849
	Rate (%)	12%	10%	22%	17%	20%	14%	17%	10%	17%	16%	15%	14%	15%	15%

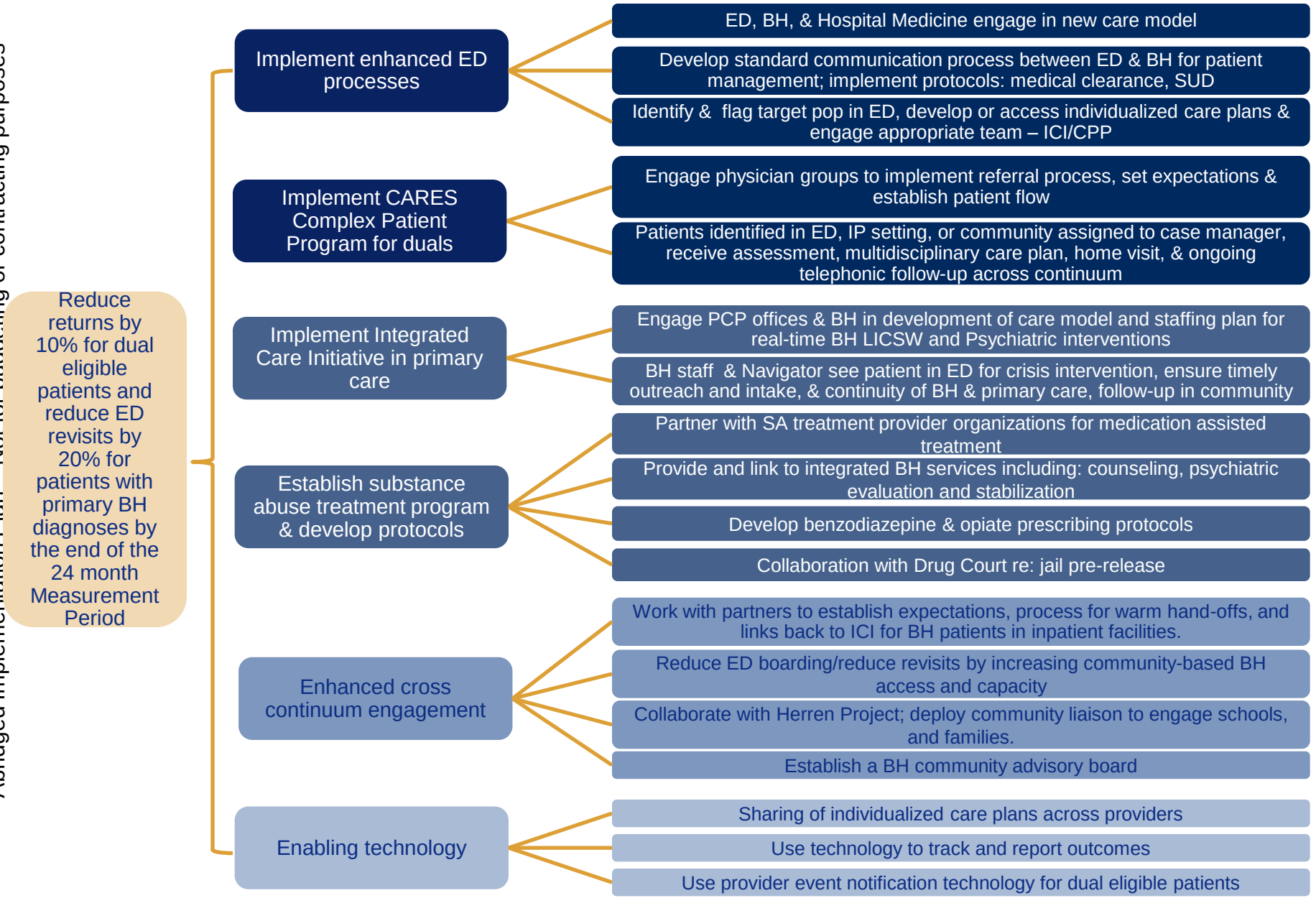
Baseline performance – ED utilization reduction

		Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Avg.	Total
Hospital-Wide	All ED Visits	3036	2713	3060	2954	3211	3326	3568	3376	3042	2870	2767	2865	3066	36788
	All ED Revisits	405	388	455	414	394	480	501	491	418	385	386	421	428	5138
	Revisit Rate	13%	14%	15%	14%	12%	14%	14%	15%	14%	13%	14%	15%	14%	14%
Target Pop: BH Patients	Target Pop ED Visits	210	229	259	234	294	246	258	234	237	261	225	276	249	2963
	Target Pop ED Revisits	24	32	37	38	30	47	35	26	36	35	43	43	36	426
	Revisit Rate	11%	14%	14%	16%	10%	19%	14%	11%	15%	13%	17%	16%	14%	14%

Estimated monthly impact

	Current Expected Events	Avoided Events	New Expected Events
Duals Returns	11 returns/month	1 (10%)	10
BH patients ED Revisits	36 ED revisits/month	7 (20%)	29

Driver Diagram



Service model (1 of 3)

Narrative description

The initial case finding approach focuses on identification of patients arriving in the BIDP ED with behavioral health complaints as the primary reason for accessing care through the ED and/or with dual eligibility. Those with behavioral health complaints as their primary reason for visiting the ED will be referred to the ICI program in which their PCP participates, or to a variety of community agencies, treatment programs, etc. Likewise, patients seen in participating PCP practices may be referred to ICI clinicians for this integrated care approach. This improved access should decrease the number of patients seeking care in the ED and offer a more effective and coordinated treatment.

Dual eligible patients who have complex clinical needs will be referred to the Community Case Management Program and, if screened as complex, will be enrolled into the program and receive care management and coordination.

Once identified, patients will receive the appropriate services as described below.

Integrated Care Initiative

The Integrated Care Initiative (ICI) focuses on establishing a community-wide approach to treating behavioral health patients in our service area and providing an integrated model of care through the co-location of services across the entire community. There is a particular focus on the expanded management of patients with substance abuse disorders and collaboration with multiple community agencies to meet the clinical and behavioral health needs of patients, school children, families and the community at large.

Behavioral Health Programming

Behavioral Health for Primary Care Patients (BID-P, PMG & PBMA Practices)

- Brief interventions with a LICSW during PCP visits for patients presenting with a behavioral health need, including screening and follow up with patients scoring 12 and above on the PHQ 9 (administered to patients 18 years and older at annual well visits)
- Outreach and intakes within 1-2 days for urgent and within five days for non-urgent referrals
- Short term counseling (8 to 10 sessions) focused on problem resolution, symptom reduction, and coping skill acquisition; support groups for parents/grandparents of children with opiate addiction
- Short term psychiatric medication evaluation and stabilization focused on reducing behavioral symptoms, improving functioning, and coordinating with medical plans of care and treatment regimens

Service model (2 of 3)

Narrative description

Outpatient Substance Abuse Treatment

- Medication-assisted treatment (includes Suboxone, Subutex and Vivitrol) from medical professionals for individuals struggling with the chronic disease of addiction through our partnership with Clean Slate Centers (CleanSlateCenters.com)
- Integrated and required behavioral health services including individual, group, and family counseling, psychiatric medication evaluation, stabilization
- Assistance with accessing primary care
- Collaboration with Plymouth Drug & Mental Health Court re: jail pre-release

Emergency Department Behavioral Health Team

- Social Worker to provide assessment, crisis intervention, and follow up for patients presenting in the Emergency Department with behavioral health issues (mental health crisis, substance abuse), including short term stabilization services to patients boarding on a section 12
- Social Work staffing: Days – 5 days (Monday through Friday); Evenings/nights – 7 days
- Nurse Practitioner to provide consultation to Emergency Department medical personnel regarding psychiatric medication requests and evaluation of patients for bridge prescriptions and patients boarding on a section 12
- Behavioral Health Team to work in collaboration with ED staff and collateral community providers to help patients: access necessary supports; ensure continuity of primary and behavioral health care; and to stabilize psychiatrically
- Collaboration with Drug Court re: Section 35
- ED BH Team will notify other providers of visit via phone call or other electronic means, e.g., secure email or fax

Community Outreach, Education, and Navigation

- Social Worker to work in close collaboration with behavioral health providers, schools, and The Herren Project (www.theherrenproject.org) in Plymouth and our surrounding communities on outreach, education, and navigation
- Promote ICI services and ensure referral and communication processes are strong and working well
- Attend community-based meetings to strengthen working relationships and stay up to date on current community offerings
- Develop and deliver, in partnership with The Herren Project, curriculum for students on substance abuse prevention programming (including participation in Project Purple and Summer Camp based activities)
- Provide family community forums that focus on education and prevention re: substance abuse
- Assist ICI patients, including patients seen by the BH team in the Emergency Department (especially school aged patients and their families), with navigating and accessing community based behavioral resources, ensuring direct connection

Service model (3 of 3)

Narrative description

Community Case Management Complex Patient Program
The Community Case Management Complex Patient Program identifies Pioneer ACO and dual eligible (aged and disabled) patients with complex clinical needs who are at high risk for return, and/or who incur high health care costs, and manages them across the continuum, focusing on transitions of care, decreasing utilization, and ensuring that optimal health is promoted.

Dual Eligible Programming
Program Population: Dual eligible (Medicare primary, MassHealth secondary insurance) patients regardless of primary care physician

Referral Process:
Patient referrals are received from a variety of different sources, e.g., PCP, VNA, inpatient hospitalist, or case manager. Once referred, a screening tool is completed, which assesses variables such as multiple diagnoses, multiple comorbidities, lack of a caregiver support, etc. The tool helps to determine whether the patient is appropriate for assignment to the program.

Patient Assignment:
Once assigned to the program, the patient is contacted by a nurse case manager, at which time a case management assessment is completed. A member of the care team (CM, SW or NP) will visit all patients deemed in need of a home visit. High risk patients are managed across the continuum of care until it is determined by the team that their status has improved, thereby no longer requiring case management intervention.

Patient Care Plan:
Patient care plans reside in Meditech and are developed, implemented, and assessed on an ongoing basis by a multidisciplinary team. Care plans may include interventions such as confirmation of home care services, ensuring medication and/or equipment procurement, monitoring timely follow-up with the patient's primary care physician, and coordination of PCP visits and/or home visits by the Nurse Practitioner, as indicated.

Service worksheet

Service Delivered

- **Care transition coaching x**
- **Case finding x**
- **Behavioral health counseling x**
- **Engagement x**
- **Follow up x**
- Transportation
- Meals
- Housing
- In home supports
- Home safety evaluation
- Logistical needs
- Whole person needs assessment
- **Medication review, reconciliation, & delivery x**
- **Education x**
- **Advocacy x**
- **Navigating x**
- Peer support
- **Crisis intervention x**
- Detox
- **Motivational interviewing x**
- **Linkage to community services x**
- **Physician follow up x**
- Adult Day Health
- Other: psychiatric medication

Personnel Type

- Hospital-based nurse
- **Hospital-based social worker x**
- Hospital-based pharmacist
- **Hospital-based NP/APRN x**
- Hospital-based behavioral health worker
- Hospital based psychiatrist
- Community-based nurse
- **Community-based social worker x**
- Community-based pharmacist
- Community-based behavioral health worker
- **Community-based psychiatrist x**
- Community-based advocate
- Community-based coach
- Community-based peer
- Community agency
- **Physician x**
- Palliative care
- EMS
- Skilled nursing facility
- Home health agency
- Other: Behavioral Health APRN
- Other: ICI Administrative Asst/Resource Specialist
- Other: Community-based Geriatric NP
- Other: Resource Specialist
- Other: Community-based RN CM

Service Availability

- **Mon. – Fri. x (DE)**
- Weekends
- **7days x (BH)**
- Holidays
- **Days x**
- **Evenings x**
- **Nights x**
- Off-Shift Hours

Service mix (1 of 12)

Service	By Whom	How Often	For How Long
INTEGRATED CARE INITIATIVE (ICI)			
HOSPITAL ED BH TEAM Engagement Contact: Includes brief assessment, crisis intervention, stabilization of patients in ED and those boarding in ED BH unit. Unit of Service: 20 min.	LICSW	1 unit per patient Up to 10 patients per 12 hrs. of ED coverage per FTE (10 encounters/day)	Length of ED visit (hours to boarding days)
Clinical Follow up Contact: Includes navigation, advocacy, teach back and referrals and ensuring connection to BID internal and community-based programs. Unit of Service: 20 min.	LICSW	1 unit per patient Up to 5 patients per 12 hrs. of ED coverage per FTE (5 encounters/day)	1 to 2 weeks post ED visit
Medication Stabilization Contact: Includes evaluation of patients and prescribing of short term psych meds while boarding in ED BH unit. Unit of Service: 30 – 60 min.	ED APRN	1 unit per patient Up to 6 patients per 8 hr. day per FTE (6 encounters/day)	Length of ED visit

Service mix (2 of 12)

Service	By Whom	How Often	For How Long
INTEGRATED CARE INITIATIVE (ICI) continued			
PCP PRACTICES – 3 sites Collaboration Contact: Includes in-person consult between LICSW, APRN or Psychiatrist and PCP regarding plan of care. Unit of Service: 15 min.	LICSW APRN Psychiatrist	1 per patient Up to 3 patients per 8 hr. day per FTE (3 encounters per day x 3 sites = 9)	2 years x 3 practices
Engagement/Initial Evaluation Contact: Includes brief intervention, diagnostic assessment and treatment planning. Unit of Service: 15, 30 or 60 min.	LICSW	1 per patient Up to 5 patients per 8 hr. day per FTE (5 encounters/day x 3 sites = 15)	1-2 days duration/patient x 3 practices
Short-term Counseling Contact: Includes motivational interviewing, PST, CBT, psycho-education, crisis intervention, transition to community-based services. Unit of Service: 30 or 60 min.	LICSW	Up to 5 patients per day per FTE (5 encounters/day x3 sites = 15)	Up to 12 weeks duration for each patient x 3 practices
Support Group Contact: Includes psycho-education Unit of Service: 90 min.	LICSW	Once a week frequency per FTE (2 encounters/day based on 12 pts. per group per week x 3 sites =6)	8 weeks duration x 3 practices

Service mix (3 of 12)

Service	By Whom	How Often	For How Long
INTEGRATED CARE INITIATIVE (ICI) continued			
PCP PRACTICES – 3 sites APRN Medication Stabilization Contact: Includes diagnostic evaluation, treatment planning, prescribing and follow up. Unit of Service: 30 or 60 min.	APRN	8 contacts per 8 hr. day per FTE (8 encounters/day x 3 sites = 24)	3-4 months duration/patient x 3 practices
Psychiatry Medication Stabilization Contact: Includes diagnostic evaluation, treatment planning, prescribing and follow up. Unit of Service: 30 to 60 min.	Psychiatrist	4 contacts per 8 hr. day per FTE (4 encounters/day x 3 sites =12)	3-4 months duration/patient
Insurance Access Follow up Contact: Includes prior authorization for visits and medications, assistance with health insurance problem solving. Unit of Service: 10 to 30 min.	Admin Assist/Resource Specialist	1-2 per patient Up to 20 contacts per 8 hr. day per FTE	2 years

Service mix (4 of 12)

Service	By Whom	How Often	For How Long
INTEGRATED CARE INITIATIVE (ICI) continued			
PCP PEDIATRIC & ADOLESCENT PRACTICE – subcontracted & rotated between 3 sites Engagement/Initial Evaluation Contact: Includes brief intervention, diagnostic assessment and treatment planning. Unit of Service: 15, 30 or 60 min.	LICSW	Up to 5 patients per 8 hr. day per FTE (5 encounters/day)	1-2 days duration/patient
Short-term Counseling Contact: Includes motivational interviewing, PST, CBT, psycho-education and crisis intervention. Unit of Service: 30 or 60 min.	LICSW	Up to 5 patients per 8 hr. day per FTE (5 encounters/day)	Up to 12 weeks duration/patient
Clinical Follow up Contact: Includes navigation, advocacy, teach back and referrals to ensure connection to BID internal programs and/or community based external services for patients needing alternate/additional services Unit of Service: 20 min.	LICSW	1per patient Up to 5 patients per week per FTE (1 encounter/day)	1-2 weeks post visit

Service mix (5 of 12)

Service	By Whom	How Often	For How Long
INTEGRATED CARE INITIATIVE (ICI) continued			
SUBSTANCE ABUSE PROGRAM Engagement/Initial Eval Contact: Includes brief intervention, diagnostic assessment and treatment planning. Unit of Service: 15, 30 or 60 min.	LICSW	Up to 5 patients per 8 hr. day per FTE (5 encounters/day)	1-2 days duration/ patient
Short-term Counseling Contact: Includes motivational interviewing, PST, CBT, psycho-education and crisis intervention. Unit of Service: 30 or 60 min.	LICSW	Up to 5 patients per 8 hr. day per FTE (5 encounters/day)	Up to 12 weeks duration/patient
Support Group Contact: Includes psycho-education, harm reduction) Unit of Service: 90 min.	LICSW	Once a week frequency per FTE (2 encounters)	8 weeks duration x 2 groups
Clinical Follow up Contact: Includes navigation, advocacy, teach back and referrals to ensure connection to BID internal programs and/or community based external services for patients needing alternate/additional services Unit of Service: 20 min.	LICSW	1 per patient Up to 5 patients per week per FTE (1 encounter/day)	1-2 weeks post visit

Service mix (6 of 12)

Service	By Whom	How Often	For How Long
INTEGRATED CARE INITIATIVE (ICI) continued			
COMMUNITY OUTREACH & PREVENTION Clinical Follow up Contact: Includes navigation, advocacy, teach back and referrals to ensure connection to BID internal programs and/or community based external services for patients needing alternate/additional services Unit of Service: 30 min.	LICSW	1 per patient/family Up to 5 patients per week per FTE (1 encounter/day)	1-2 weeks post visit
Education Session Contact: Includes teaching, training and prevention. Unit of Service: 60, 90 or 120 min.	LICSW	Up to 50 participants 4 times per year (1 encounter/day)	2 years

Service mix (7 of 12)

Service	By Whom	How Often	For How Long
DUAL ELIGIBLE COMPLEX PATIENT PROGRAM			
Review of Discharge/ED report for program screening Unit of Service: identified patients	Community Resource Specialist	Daily Up to 10–11 new patients per day; 203 per month	Up to 2 hours/day
Dual eligibility insurance confirmation Unit of Service: insurance confirmations	Community Resource Specialist	Daily Up to 10–11 confirmations per day; 203 per month	Up to 2 hours/day
Conferring with Case Manager on patient assignment Unit of Service: patients	Community Resource Specialist	Daily 3-5 patients per day	Up to 1 hour/day
Data entry for patient assignment, management, telephonic follow-up, and discharge Unit of Service: patients	Community Resource Specialist	Daily Up to 10-20 per day	Up to 3 hours/day
Follow-up patient calls Unit of Service: patient calls	Community Resource Specialist	Daily Up to 20-30 calls per day	60 – 80 patients/month Up to 6 months or longer
Tracking of patients across transitions of care Unit of Service: patients	Community Resource Specialist	Daily Up to 20–30 patients per month	60 – 80 patients/month Up to 6 months or longer

Service mix (8 of 12)

Service	By Whom	How Often	For How Long
DUAL ELIGIBLE COMPLEX PATIENT PROGRAM Continued			
Identifying and securing community resources, conferring/collaborating with Case Manager/Nurse Practitioner Unit of Service: calls	Community Resource Specialist	Daily Up to 10-15 calls per day on 60 -80 patients per month	Up to 6 months or longer
Conferring with VNAs, OCES, etc. Unit of Service: contacts	Community Resource Specialist	Daily Up to 5-10 contacts per day on 60-80 patients per month	Up to 6 months or longer
Screening, assessment and care plan completion Unit of Service: patients	Community Nurse Case Manager	Daily 7 patients per day, 60-80 patients per month (7 encounters/day)	Up to 6 months or longer
Coordination of case management interventions, e.g. NP home visit, coordinating community resources, transition management, telephonic follow-up Unit of Service: calls	Community Nurse Case Manager	Daily Average 20 calls per day on 60-80 patients per month (20 encounters/day)	Up to 4 hours/day
Case Manager Home Assessment Visits Unit of Service: home visit	Community Nurse Case Manager	2 visits per day as needed for complex patients (2 encounters/day)	Up to 2 months or longer

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Service mix (9 of 12)

Service	By Whom	How Often	For How Long
DUAL ELIGIBLE COMPLEX PATIENT PROGRAM Continued			
Conferring with Nurse Practitioner, complex case management team and community partners Unit of Service: calls	Community Nurse Case Manager	Daily, and as needed 7 calls per day on 30-40 patients per month (7 encounters/day)	Up to 6 months or longer
Attendance at weekly SNF meetings Unit of Service: meetings	Community Nurse Case Manager	3 -5 meetings weekly	Ongoing, 2 years
Attendance at Community Partner (VNA/SNF/ALF) meetings Unit of Service: meetings	Community Nurse Case Manager	Quarterly	Ongoing, 2 years
Healthy Living Center of Excellence Teaching Unit of Service: teaching session	Community Nurse Case Manager	Annually; 12 sessions	Ongoing, 2 years
Screening, assessment and care plan completion; explanation of social work role, identify/address presenting problem, patient engagement Unit of Service: patients	Community Social Worker	Daily 7 patients per day, 15-20 patients per month (7 encounters/day)	Up to 2 hours/day Up to 6 months or longer

Service mix (10 of 12)

Service	By Whom	How Often	For How Long
DUAL ELIGIBLE COMPLEX PATIENT PROGRAM Continued			
Identifying and assisting with securing community resources/information, follow up contact Unit of Service: calls	Community Social Worker	Daily Average 7 calls per day (7 encounters/day)	Up to 2 hours/day Up to 6 months or longer
Social Work Home Visits; to include home assessment, providing resources for identified issues, e.g., hoarding, unsafe conditions, etc. Unit of Service: visits	Community Social Worker	2 visits per day as needed for complex patients (2 encounters/day)	Up to 2 hours Up to 6 months or longer
Conferring with Nurse Practitioner, complex case management team, community partners Unit of Service: calls	Community Social Worker	Daily and as needed 7 calls per day (7 encounters/day)	Up to 2 hours Up to 6 months or longer
Attendance at Community Partner (VNA/SNF/ALF) meetings Unit of Service: meetings	Community Social Worker	Quarterly	Ongoing, 2 years

Service mix (11 of 12)

Service	By Whom	How Often	For How Long
DUAL ELIGIBLE COMPLEX PATIENT PROGRAM Continued			
Confers with Community Case Management team Unit of Service: calls	Community Nurse Practitioner	Daily 7 calls per day on 60-80 patients per month (7 encounters/day)	Up to 1 hour/day Up to 6 months or longer
Clinical collaboration with other care providers Unit of Service: call	Community Nurse Practitioner	Daily Average 10 calls per day on 30-40 patients per month (10 encounters/day)	1 hour/day Up to 6 months or longer
Home visits Unit of Service: visit	Community Nurse Practitioner	Daily 2 per day on 30-40 patients per month (2 encounters/day)	2 hours/day

Units of service hired at my organization/# FTE	
Psychiatrist LICSW • ICI - Supervisor 1.00 • ICI - BID Plymouth Practice 1.00 • ICI - PMG Practice 1.00 • ICI - PBMA Practice 1.00 • ICI - Outpatient Substance Abuse 1.00 • ICI – ED BH 1.00 • CPP - Community CM 1.00	1.00 FTE 7.00 FTE

Service mix (12 of 12)

Units of service hired at my organization/# FTE (continued)	
APRN • ICI - BID Plymouth Practice 0.50 • ICI - PMG Practice 0.50 • ICI - PBMA Practice 0.50 • ICI - ED 1.00 • CPP - Community CM 1.00 Community Nurse Case Manager Resource Specialist Aftercare Specialist TOTAL FTEs – 14.5	3.50 FTE 1.00 FTE 1.00 FTE 1.00 FTE
Units of service contracted/# FTE **(Behavioral health services for pediatric patients)**	1.8 LICSWs 4 hour/week child adolescent psychiatrist

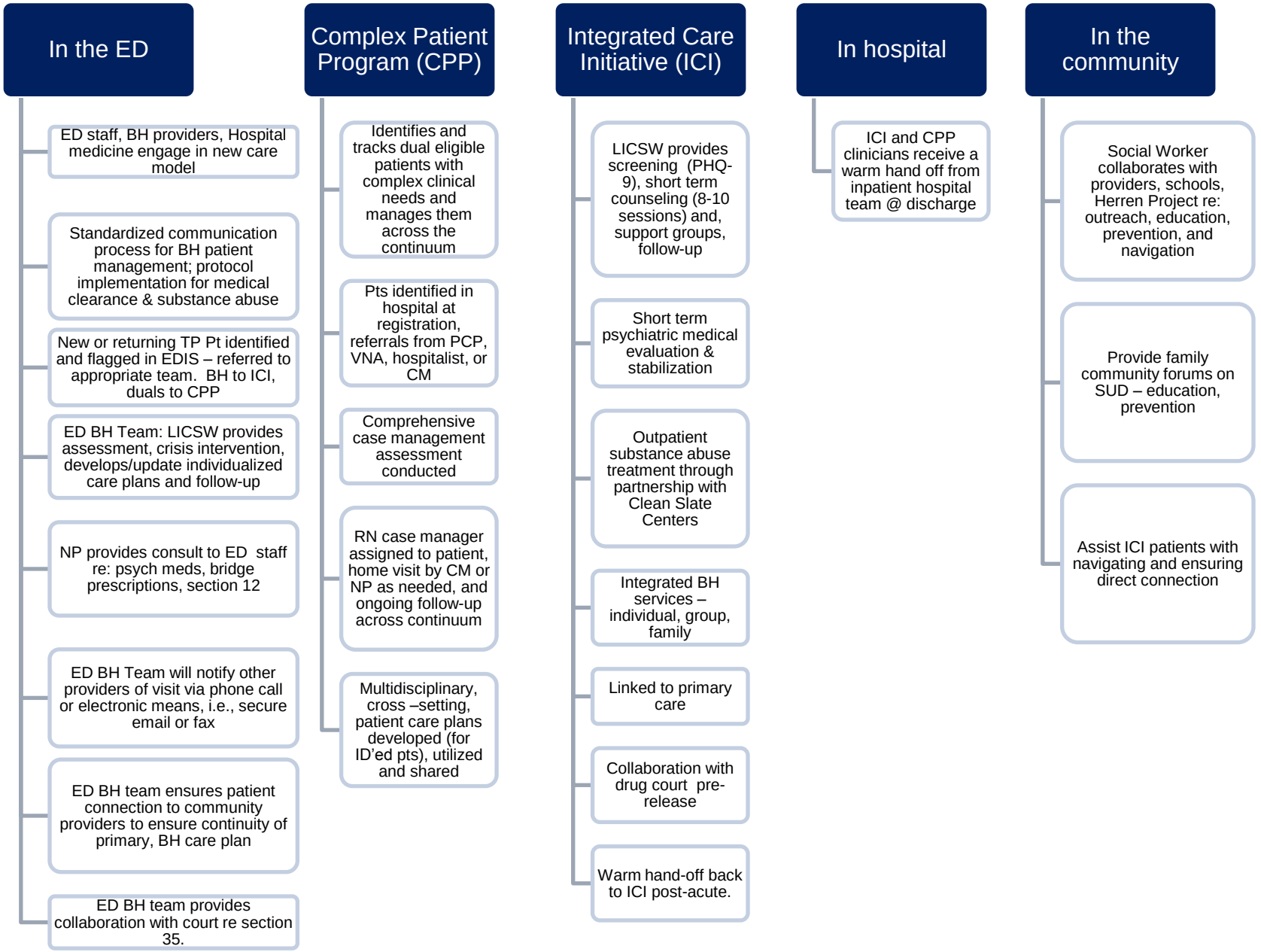
List of service providers/community agencies (1 of 2)

Type of Service Provider	Community Agency Name	New or Existing Relationship
ICI Program		
Behavioral Health/Outpatient	Northeast Counseling	New
Substance Abuse Prevention/Education	Herren Project	New
Substance Abuse	Clean Slate Centers	New
Behavioral Health/Inpatient & Outpatient	McLean Hospital	Existing
Behavioral Health (Contracted ESP)	Child and Family Services	Existing
BH (MH and Substance Abuse, Inpt/Outpt)	High Point	Existing
State Agencies	DMH, DCF	Existing
Behavioral Health/Outpatient	FCP, SSMH/Bayview, South Bay, COVE, Psychology Associates	New
Forensic/Community	Plymouth Mental Health and Drug Court, Police, Fire, EMS	Existing
Educational	Plymouth Public Schools System, PYDC	Existing
Housing	Plymouth County Outreach Committee	Existing

List of service providers/community agencies (2 of 2)

Type of Service Provider	Community Agency Name	New or Existing Relationship
Duals Complex Patient Program		
Visiting Nurse Associations	Bayada Home Health Care, Visiting Nurse Association of Cape Cod, Gentiva Home Health & Hospice, Norwell VNA & Hospice	Existing
Hospice	Cranberry Hospice	Existing
Skilled Nursing & Rehabilitation Facilities	Bay Path Rehabilitation Nursing Center, Golden Living Center – Plymouth, Life Care Center of Plymouth, Plymouth Rehabilitation & Health Care Center, Wingate at Silver Lake	Existing
Specialized services and programs with a focus on the senior population	Old Colony Elder Services	Existing
Senior Centers providing services and programs to the elder population	Local Council on Aging	New and Existing
Services similar to Old Colony Elder Services but for persons age 18 - 59	Mass Rehab Commission - Home Care Assistance Program	Existing
Chair care/ambulance transfer	Eascare	Existing
Transportation	Gatra, Pilgrim Taxi	Existing
Medication/DME/supplies; identified patient needs	CVS Patient Assistance Program	Existing
Adult Foster Care	South Shore Support Services, Inc., Caregiver Homes	Existing
Private duty care	Multiple Private Duty Agencies	Existing
Oxygen, DME	Respracare	Existing

Summary of services



Cohort-wide standard measures – Hospital utilization measures

Data elements	All	Target Population- ED BH	Target Population- Duals
1. Total Discharges from Inpatient Status (“IN”)	x		x
2. Total Discharges from Observation Status (“OBS”)			x
3. SUM: Total Discharges from IN or OBS (“ANY BED”)	x		x
4. Total Number of Unique Patients Discharged from “IN”			x
5. Total Number of Unique Patients Discharged from “OBS”			x
6. Total Number of Unique Patients Discharged from “ANY BED”			x
7. Total number of 30-day Readmissions (“IN” to “IN”)	x		x
8. Total number of 30-day Returns (“ANY BED” to “ANY BED”)	x		x
9. Total number of 30-day Returns to ED from “ANY BED”			
10. Readmission rate ("IN readmissions" divided by "IN")	x		x
11. Return rate (ANY 30-day Returns divided by “ANY BED”)	x		x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – ED utilization measures

Data Elements	All	Target Population ED BH	Target Population (Duals)
12. Total number of ED visits	x	x	
13. Total number of unique ED patients		x	
14. Total number of ED visits, primary BH diagnosis			
15. Total number of unique patients with primary BH diagnosis			
16. Total number of ED visits, *any* BH diagnosis			
17. Total number of unique patients with any BH diagnosis			
18. Total number of 30-day ED revisits (ED to ED)	x	x	
19. Total number of 30-day revisits (ED to ED), primary BH diagnosis			
20. Total number of 30-day revisits (ED to ED), any BH diagnosis			
21. ED revisit rate	x	x	
22. ED BH revisit rate (primary BH diagnosis only)			
23. ED BH revisit rate (any BH diagnosis)			
24a. Median ED LOS (time from arrival to departure, in minutes)		x	
24b. Min ED LOS (time from arrival to departure, in minutes)			
24c. Max ED LOS (time from arrival to departure, in minutes)			
25a.Median ED LOS (time from arrival to departure, in minutes), primary BH diagnosis			
25b. Min ED LOS (time from arrival to departure, in minutes), primary BH diagnosis			
25c. Max ED LOS (time from arrival to departure, in minutes), primary BH diagnosis			
26a. Median ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)			
26b. Min ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)			
26c. Max ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)			

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Service delivery measures

Data elements	Target Population ED BH	Target Population PCP BH	Target Population BH ED+PCP Deduplicated	Target Population (Duals)
27. Total number of unique patients in the target population	x			x
28. Number of acute encounters for target population patients	x			x
29. For acute encounters in measure #28, number of these with any CHART service provided after discharge and within 48 hours	x			x
30. Total number of contacts for the target population	x			x
31. Average number of contacts per patient served				
32a. Min number of contacts for patients served				
32b. Max number of contacts for patients served				
33. Number of units of service provided by service modality (including, e.g., phone call, virtual interaction, face to face in office, face to face in home, etc.)	x			x
34. Number of units of service provided, by service types (e.g., care coordination, medication optimization, clinical care, counseling, needs assessment, etc.)	x			x
35. Number of units of service provided, by role type (NP, LICSW, Pharmacist, Community Health Worker, Peer)	x			x
36. Average time (days, months) enrolled in CHART program per patient				
37. Range time (days, months) enrolled in CHART program per patient				
38. Proportion of target population patients with care plan				

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Payer mix

Data elements	Medicare	Medicaid	Commercial
39. Count of patients in the Target Population (BH)	x	x	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Program-specific measures (1 of 2)

Measure Definition	Numerator	Denominator
Integrated Care Initiative		
% of ICI (ED and PCP/BH) patients referred to Clean Slate	# of Pts referred to Clean Slate	# of patients enrolled in ICI program
PHQ9 baseline scores	Average PHQ9 score of patients from (A)	
PHQ9 disenrollment/discharge scores	Average PHQ9 score of patients from (C)	
Herren: Support group enrollment	Count of # enrolled	
Herren: Support group patient experience/satisfaction	Qualitative survey	

Bolded measures will have details finalized during the first month of the Measurement Period.

Program-specific measures (2 of 2)

Measure	Numerator	Denominator
Total Discharges to SNF (Target Population-Duals)	Count of the number of IN discharges for the target population that were discharged to a skilled nursing facility	N/A
Total Discharges to Home Health (Target Population-Duals)	Count of the number of IN discharges for the target population that were discharged to home health	N/A
Total Discharges to Home (Target Population-Duals)	Count of the number of IN discharges for the target population that were discharged to home	N/A
Total number of primary BH ED visits discharged home (Target Population-BH)	Count of ED visits that were discharged to home	N/A
Total number of primary BH ED visits admit to med/surg (Target Population-BH)	Count of ED visits that were admitted to med/surg	N/A
Total number of primary BH ED visits admit/transfer to psych unit (Target Population-BH)	Count of ED visits that were admitted/transferred to psych unit	N/A

Continuous improvement plan

1. How will the team share data?	CHART Team Meetings – weekly Quality Committee of the BID-P Board – quarterly BID-P Board - quarterly
2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)?	Weekly in preparation for CHART Team Meeting. Data Analyst will be tasked with interpreting and displaying data in run charts, pivot tables, etc.
3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)?	Senior Leadership Meeting – monthly BID-P Board - quarterly
4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)?	ED Team – initially weekly, migrate to monthly Practice Teams – monthly Complex Team - monthly
5. How often will your community partners review data (e.g., weekly, monthly)?	BH Community Partners – quarterly Complex Community Partners (VNA, SNF, Elder Services) – quarterly CFS & McLean – daily ED tracker; weekly meeting
6. Which community partners will look at CHART data (specific providers and agencies)?	The following community partners will meet quarterly to review trending data: BH Community Partners: Plymouth District Mental Health & Drug Court, Northeast Health Services, McLean Hospital, Child & Family Services, High Point, Cove, Psychological Associates, Clean Slate, DMH, South Bay Mental Health, Herren Project, Plymouth Public Schools, PYDC, Family Continuity Program Complex Community Partners: Cape Cod VNA, Gentiva Home Health, Norwell VNA, Bayada Home Health, Bay Path, Golden Living, Life Care – Plymouth, Plymouth Rehab, Wingate
7. Will the quality committee of your board review CHART reporting (e.g., quarterly)?	The PM will update the Quality Committee of the BID-P on a quarterly basis.

Continuous improvement plan

8. Who will collect measures and produce reporting for Cohort-wide and program specific measure (e.g., Data Analyst, PM, ID)?	**Cohort-Wide**	**Program specific**
	The Director of Financial Planning will work with the Financial/Data Analyst to build template for ongoing data capture. Analyst will be responsible for monthly data extraction.	Same, however, may rely on expertise of hospital IT staff.
9. What is your approximate level of effort to collect these metrics?	**Cohort-Wide**	**Program specific**
	High effort	High effort
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures?	Data is readily available in our Decision Support System and staff has demonstrated their ability to pull similar data sets.	
11. How will you know when to make a change in your service model or operational tactics?	During CHART 1, this team demonstrated their ability to assess performance/outcomes and make operational changes as needed to assure improved access to quality care. The same approach will be taken during CHART 2.	

Enabling Technologies plan

Functionality	User	Vendor	Cost
IT Community Connectivity Liaison	Community partners	Jacquelyn Petralia	$163,800 (salary and fringe)
Enhance team communication by allowing providers to meet “virtually” and communicate about ongoing patient needs by way of video conferencing.	CCM staff, physicians, Community partners	Polycom RealPresence	$28,400
Secure exchange of patient information with our care partners via Mass HIway.	Community partners who are participating in Mass HIway	Mass HIway	5 LTC - $50,000 5 BH - $2,750
Care documentation and communication	ICI office staff	HP computers and monitors purchased through Computer Discount Warehouse	$22,000
Interfaces – Establish connection to Mass HIway for high volume community providers who do not have connectivity. Communication between systems when Mass HIway cannot be used (ex. outside lab, pharmacy, etc.)	Team staff, community providers	Mass HIway	$50,000
CPP team notification when Dual Eligible patient presents at ED	CPP team	Patient Ping	$2,000

Enabling Technologies plan – Q&A

1. How are you going to identify target population patients in real-time?
    - Dual Eligible Patients
        - Identified at point of registration and flagged in Meditech
        - Appear on daily report
        - Referrals from physician offices
    - Behavioral Health Patients
        - Emergency Department
        - Identified on ED Tracker
        - Warm hand off; phone call
    - ICI Practices
        - Referrals from physician offices

2. How will you measure what services were delivered by what staff?
    - Dual Eligible Patients – Allscripts
    - Behavioral Health Patients
        - ED – Meditech
        - ICI Practices – eCW with Aftercare Specialist manually tracking

3. How will you measure outcome measures monthly?
    - Decision Support System

4. What tool/platform will you use to facilitate cross-setting and multi-disciplinary coordination of care?
    - eCW, GE Centricity, Meditech – secure/direct messaging via MassHIway

5. Where will individual care plans reside, and what is the plan for making them available on a need-to-know basis 24/7 in the ED, hospital, and ambulatory settings?
    - Care plans will reside in Meditech

6. Do you have a method for identifying what clinical services your target population accesses?
    - Services delivered by CHART-clinicians will be measured using Meditech, eCW, and manually by Aftercare Specialist

Other essential investments

Other Investments	Budget Required
Herren Project Provide school based programs aimed at early intervention, education and outreach to the Plymouth High Schools.	$100,000
High Point 2.8 FTE LCISWs	$481,520 ($394,474 CHART funded)
McLean Contracted LICSW and psychiatric care (Pedi Project)	$160,000

Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	October 1, 2015
Post jobs	Complete
New hires made	In process Complete by 10/1/15
Execute contracts with service delivery partners: Primary care offices, Herren Project, McLean	Herren – 7/1/15; McLean – 9/1/15; PMG – 9/15/15
Execute contracts with Patient Ping, MeHI (Mass HIway)	Patient Ping – 5/2/15 MassHIway – 8/13/13
Admissions reduction initiatives and staffing in-place to support 50% of planned patient capacity	11/30/15
Admissions reduction initiatives and staffing in-place to support 100% of planned patient capacity	1/1/16
ED visit reduction initiatives and staffing in-place to support 50% of planned patient capacity	11/30/15
ED visit reduction initiatives and staffing in-place to support 100% of planned patient capacity	1/1/16
First test report of services measures	9/15/15
Enabling technology – Hardware secured and installed	In process & ongoing
Enabling technology – Hardware tested	In process & ongoing
Trainings completed, Patient Ping,	In process & ongoing
First patient seen	10/1/15

Community partners/subcontractors

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
McLean	115 Mill St. Belmont, MA 02478	www.mcleanhospital.org/	Philip Levendusky, PhD	Sr. VP, Business Development	617-855-2328	levendp@mclean.harvard.edu
The Herren Project	PO Box 131 Portsmouth, RI 02871	www.theherrenproject.org/	Kevin Mikolayzk	President, Board of Directors	401-243-8590	kevin@theherrenproject.org
High Point	98 Front Street, 3rd floor New Bedford, MA 02740	www.hptc.org	Daniel Mumbauer	President	774-628-1095	dmumbauer@hptc.org